

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1820
Registrar's No. 50

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH

(a) County **BUCHANAN**
(b) City or town **ST. JOSEPH**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **STATE HOSPITAL No. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 mos. 2 mos. 18 ds.**
(Specify whether
In this community **all of life**
years, months or days)

3. (a) PRINT FULL NAME

Henry C. Jones

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex **male**

5. Color or
race **white**

6. (a) Single, widowed, married,
divorced **single**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if
alive years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

68

2

2

2

hr.

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

Cook

11. Industry or business

12. Name

no information

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

no information

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

L. H. Jones

(b) Address

Maryville, Mo.

17. (a) **removal**
(Burial, cremation, or removal)

(b) Date thereof

1-12-41
(Month) (Day) (Year)

(c) Place: burial or cremation

Maryville, Mo.

18. (a) Signature of funeral director

James Funeral Home

(b) Address

Maryville, Mo.

19. (a) **1-12-41**
(Date received local registrar)

(b) **H. H. H. H. H.**
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Podaway**
(c) City or town **rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.R. Marquette**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **12**
year **1941** hour **9:50** minute **0** M.

21. I hereby certify that I attended the deceased from
Oct. 25 19**39** to **Jan. 12** 19**41**
that I last saw him alive on **11** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **pneumonia**

Duration

1 wk.

Due to **arteriosclerosis**

Due to **107**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature **J. J. O'Neil** (M. D. or other)
Address **St. Joseph, Mo.** Date signed **1/12/41**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Clara M. Price

Licensed Embalmer No. *1822*

P. O. Address *Maryville, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.